89-554

No. ———

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

HENNEPIN COUNTY AND HENNEPIN COUNTY MEDICAL CENTER,

Petitioners

v.

LOUIS W. SULLIVAN, M.D.,

Respondent

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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QUESTION PRESENTED

Whether 42 U.S.C. § 1395x(v)(1)(A) imposes a statutory duty upon the Secretary of the Department of Health and Human Services to provide a retroactive corrective adjustment whenever his methods of cost calculation fail to reimburse adequately all reasonable costs of a Medicare health care provider and whether the Secretary's obligation is satisfied by providing for annual adjustments to a provider's periodic Medicare payments.

PARTIES TO THE PROCEEDINGS

Petitioners are Hennepin County, a body politic and corporate, duly organized under the laws of the state of Minnesota, and Hennepin County Medical Center, a licensed public hospital, owned and operated by Hennepin County.

Respondent is Louis W. Sullivan, M.D., in his official capacity as Secretary of the United States Department of Health and Human Services.*

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* Louis W. Sullivan, the current Secretary of Health and Human Services, was substituted pursuant to Fed. R. App. P. 43(c)(1) in the court of appeals. Otis R. Bowen, M.D., was Secretary of Health and Human Services when this case arose.

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LOUIS W. SULLIVAN, M.D.,

Respondent

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

Petitioners Hennepin County and Hennepin County Medical Center (jointly "HCMC") respectfully request that a writ of certiorari issue to review the decision and judgment of the United States Court of Appeals for the District of Columbia Circuit, entered on June 30, 1989.

OPINIONS BELOW

The opinion of the court of appeals is not yet reported. The opinion and judgment are reprinted in the Appendix, p. 1a, *infra*.[1]

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[1] The Appendix to this Petition is bound together with the Petition. References to the Appendix are cited herein as "——a."

The opinions of the U.S. District Court for the District of Columbia are reported at 689 F. Supp. 1, and are reprinted in the Appendix at 18a, *infra*.

JURISDICTION

The judgment of the U.S. Court of Appeals for the District of Columbia Circuit was entered on June 30, 1989. This Court has jurisdiction to review the judgment of the court of appeals by writ of certiorari pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Petitioners assert that the Secretary of Health and Human Services ("Secretary") violated 42 U.S.C. § 1395x (v)(1)(A), the provision of the Medicare Act which directs him to grant a retroactive corrective adjustment to a health care provider when the Secretary's chosen methods of cost calculation result in inadequate reimbursement to the provider. The text of 42 U.S.C. § 1395x (v)(1)(A) is reprinted in full in the Appendix, at 38a, *infra*.

STATEMENT OF THE CASE

Petitioners brought suit in the district court under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.*, commonly known as the Medicare Act. Jurisdiction in the district court was based on 42 U.S.C. § 1395oo (f) and 28 U.S.C. § 1331.[2]

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[2] In Count I of their complaint, petitioners challenged the Secretary's denial of HCMC's request for an exception from the limitations on reimbursable costs for medical education expenses in the 1980 cost reporting year pursuant to regulations permitting providers to seek such an exception. The district court granted summary judgment in favor of respondent on Count I. (31a). The U.S. Court of Appeals for the District of Columbia Circuit affirmed the judgment of the district court as to Count I. (15a). Petitioners do not seek review of that ruling.

HCMC is a teaching hospital with a large graduate medical education program. (22a). Health care providers with large graduate medical education programs experience higher operating costs than providers which do not operate such programs. (31a). Petitioners maintain that for HCMC's 1980 cost year, the aggregate reimbursement produced by the Secretary's chosen method of determining HCMC's reasonable costs proved to be inadequate, because the method did not adequately reimburse HCMC's reasonable indirect medical education teaching costs. In Count II of their complaint, petitioners maintained that pursuant to 42 U.S.C. § 1395x(v)(1)(A), the Secretary was obligated to grant HCMC a retroactive corrective adjustment to its 1980 reimbursement.

The district court granted summary judgment in favor of HCMC on Count II. (31a). The district court found that health care providers with graduate medical education programs experience higher operating costs and that because of these extra expenses, the Secretary had promulgated the "teaching adjustment factor." *Id.* The court found that the Secretary's regulations regarding the teaching adjustment amounted to a recognition that the methods of setting the cost limits for providers with educational programs were inadequate, resulting in the potential for inadequate reimbursement. *Id.* The district court remanded to the Secretary in light of this "acknowledgment that a given [cost] method was faulty and because the Secretary failed to adequately consider whether HCMC had demonstrated that it individually suffered inadequate reimbursement and might be entitled to a retroactive corrective adjustment." *Id.*

On June 1, 1988, the district court clarified its order of March 17, 1988. (35a). The district court stipulated that in demonstrating its individual inadequate reim-

bursement, HCMC must proceed exclusively via 42 C.F.R. § 405.460(f).[3] (37a).

The United States Court of Appeals for the District of Columbia Circuit reversed the district court's remand of Count II. (17a). The appellate court found that because HCMC failed to demonstrate that it was entitled to an exception from the routine cost limits [Count I], it therefore was not entitled to a retroactive corrective adjustment pursuant to section 1395x(v)(1)(A) of the Medicare Act. (16a). In reaching this decision, the appellate court found that the Secretary's obligation to provide suitable retroactive corrective adjustments pursuant to section 1395x(v)(1)(A) was satisfied by regulations adopted pursuant to section 1395g of the Medicare Act, which provide for adjusting the amount of interim Medicare payment received. (16a).

At the heart of this case is the proper interpretation of a clause in the Medicare Act which mandates that the Secretary shall

> provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

42 U.S.C. § 1395x(v)(1)(A)(ii) (hereinafter "clause (ii)"). The Secretary maintained below, and the Court of Appeals apparently agreed, that this language requires the Secretary to engage in a periodic "book balancing" of

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[3] Pursuant to his authority to issue cost limits, the Secretary issued regulations providing for certain exceptions to the routine limits. One of these regulations, 42 C.F.R. § 405.460(f)(4) [now 42 C.F.R. § 413.30(f)(4)] provided that a hospital, such as HCMC, which operates graduate medical education programs can seek an exception to the cost limits for increased indirect costs associated with those programs. HCMC's attempt to demonstrate its entitlement to an exception pursuant to 42 C.F.R. § 405.460(f)(4) was the basis of Count I of petitioners' complaint.

the amount of interim Medicare payments received by providers with the amount shown as due on provider's year-end cost report. The Secretary, and the court below, took this position despite the fact that another provision of the Medicare Act, section 1395g, already provides for a year-end book balancing of a provider's periodic payment.[4] Moreover, the court below accepted the Secretary's interpretation of the relevant statutory section despite the fact that every other appellate court but one to consider the Secretary's argument has rejected it. The court did not cite, let alone discuss or distinguish, the appellate court decisions directly rejecting the interpretation of section 1395x(v)(1)(A) urged by the Secretary and adopted by the court. The court below also relied on *dicta* from this Court's decision in *Bowen v. Georgetown University Hospital*, —— U.S. ——, 109 S.Ct. 468 (1988), a case that did not address the issue presented here, as support for its interpretation of section 1395x (v)(1)(A).

In *Georgetown*, this Court rejected the Secretary's claim that clause (ii) gave him authority to engage in retroactive rulemaking. In rejecting the Secretary's claim, the Court pointed to certain regulations adopted by the Secretary as evidence that the Secretary previously had interpreted section 1395x(v)(1)(A) more narrowly. *See* 109 S.Ct. at 473, *citing* 42 C.F.R. §§ 405.451(b)(1), 405.454(a), (f) (1983). According to the Court, these

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[4] Section 1395g provides, in pertinent part,

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, . . . the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments. . . ."

42 U.S.C. § 1395g.

"provisions . . . are intended to implement the Secretary's authority under clause (ii)," 109 S.Ct. at 473 n.2, and "are the only regulations that expressly contemplate the making of retroactive corrective adjustments." *Id.* at 473.

The Court's statement regarding the purpose of 42 C.F.R. §§ 405.451(b)(1), 405.454(a), (f) is *dicta*. Neither those regulations, nor the relationship between those regulations and section 1395x(v)(1)(A) was at issue in *Georgetown*. Moreover, the regulations cited by the Court were *not* promulgated to implement clause (ii). Although 42 C.F.R. § 405.451(b)(1) contains language that to some extent parallels the language of section 1395x(v)(1)(A), it goes on to define the "retroactive adjustment" as "the difference between the amount received by the provider during the year for covered services from both [the Medicare program] and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services rendered to beneficiaries during the year." Courts that have been asked specifically to address the Secretary's occasional claim that these regulations satisfy clause (ii) routinely have rejected that argument. *See* p. 8, *infra*.

REASONS FOR GRANTING THE WRIT

1. The court of appeals' decision below warrants review because the court's interpretation of 42 U.S.C. § 1395x(v)(1)(A) is in direct conflict with the interpretations of that section by the Court of Claims and the courts of appeal for the Second, Fifth, and Ninth circuits. This split among the circuit courts creates conflict and confusion in the administration of the Medicare Act. The split in lower federal court decisions on this issue is not due to factual idiosyncrasies in the cases presented. The confusion arises from the varied litigating strategies taken by the Secretary regarding the meaning of section 1395x(v)(1)(A). Until this Court rules definitively on

the meaning of the statute, the Secretary will continue to exploit this confusion to his benefit, and to the detriment of uniform application of the statute to Medicare providers.

The D.C. Circuit's interpretation of section 1395x(v)(1)(A) is inconsistent with the plain meaning and Congressional purpose of the Medicare Act. It also violates a standard and well-accepted rule of statutory construction that a statute should be interpreted to give meaning and effect to all its provisions.

2. This Court has not had the opportunity to review the important question of law presented by this case. Indeed, *dicta* from this Court's decision in *Bowen v. Georgetown University Hospital* inadvertently has contributed to the confusion surrounding the meaning of clause (ii). In *Georgetown*, the Court resolved the legality of the Secretary's attempt to engage in retroactive rulemaking applicable to all Medicare providers. The retroactive corrective adjustment provision of section 1395x(v)(1)(A) was at issue in that case only to the extent the Secretary relied on the provision to justify his purportedly broad retroactive rulemaking authority. Although this Court ruled unequivocally that section 1395x(v)(1)(A) did not authorize the Secretary's attempt at retroactive rulemaking, the Court did not address or attempt to define the precise contours of the retroactive corrective adjustment provision. The Court's reference to regulations adopted pursuant to section 1395g, a section of the Act not at issue in *Georgetown*, has led to confusion regarding the appropriate interpretation of the statute. Until this Court addresses directly the meaning of section 1395x(v)(1)(A), this confusion will continue.

I. THE D.C. CIRCUIT'S OPINION SHOULD BE REVIEWED BECAUSE IT CONFLICTS WITH DECISIONS OF OTHER CIRCUIT COURTS INTERPRETING THE SAME STATUTE AND IS INCONSISTENT WITH THE MEANING AND PURPOSE OF THE MEDICARE ACT

In promulgating the Medicare Act in 1965, Congress made clear its intent that providers were to be reimbursed, as nearly as possible, for all costs necessarily incurred in the efficient delivery of health care services to Medicare beneficiaries. The Senate Report accompanying the Medicare Act states Congress' explicit intent:

> Although [reimbursement] may be made on various bases the objective, whatever method of computation is used, will be to approximate as closely as practicable the actual cost (both direct and indirect) of services rendered to the beneficiaries of the program so that under any method of determining costs, the costs of services of individuals covered by the program will not be borne by individuals not covered, and the costs of services of individuals not covered will not be borne by the program.

S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. & Admin. News 1943, 1976.

The retroactive corrective adjustment provision in clause (ii) is consistent with this Congressional intent. *See Regents of University of California on behalf of University of California, Davis Medical Center v. Heckler*, 771 F.2d 1182, 1189 (9th Cir. 1985) (hereinafter "*Regents v. Heckler*"). Moreover, as the majority of appellate courts that have considered the issue have agreed, this purpose is not served by reading section 1395x(v)(1)(A) as duplicative of section 1395g.

In *Regents v. Heckler*, the Ninth Circuit interpreted section 1395x(v)(1)(A) in circumstances similar to those presented here. There, as here, the Secretary argued that section 1395x(v)(1)(A) required nothing more

of the Secretary than a year-end "book balancing" of the provider's account. The Ninth Circuit found the Secretary's reading of the statute to be inconsistent with the plain language employed by Congress. 771 F.2d at 1189. The court interpreted the Medicare Act as providing for two distinct types of adjustment: (1) 42 U.S.C. § 1395g provides a year-end adjustment to rectify errors produced by the monthly installment payment procedure; and (2) 42 U.S.C. § 1395x(v)(1)(A) mandates a retroactive corrective adjustment whenever necessary to correct flaws in the determination of the aggregate reimbursement due a provider as a result of inaccurate methods of determining reasonable costs. *Id.*

The Ninth Circuit pointed out the potential for redundancy and wasteful duplicity in any other construction of the statute: "That the retroactivity clause of § 1395x(v)(1)(A) was not intended to merely ameliorate auditing errors is evident by Congress' provision for such relief in § 1395g . . . ." *Id.* at 1189.

Similarly, in *Springdale Convalescent Center v. Mathews*, 545 F.2d 943 (5th Cir. 1977), the Fifth Circuit found that

> the Medicare Act contemplates a bifurcated structure in relation to cost determinations . . . . Section 1395g establishes an interim payment procedure with necessary adjustments for previously made overpayments or underpayments. The methods for determining a provider's reasonable cost authorized under section 1395x(v)(1)(A) are designed to compute correctly a provider's reimbursable costs, *a function completely different from the interim payment procedure of section 1395g* . . .

545 F.2d at 954 (emphasis added). The court found, as the Ninth Circuit would later agree, that limiting the scope of section 1395x(v)(1)(A) to adjustments to a provider's unsettled audits was contrary to the Congressional purpose. *Id.*

In *Whitecliff, Inc. v. U.S.*, 536 F.2d 347 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969 (1977), the Court of Claims also grappled with the government's argument that section 1395x(v)(1)(A) requires only an annual, year-end adjustment when the total of the interim monthly payments made under section 1395g are found to be inadequate on the basis of the cost report filed at year end. The court refused to entertain that interpretation: "The wording of the statute leaves no room for such an interpretation. [Section 1395x(v)(1)(A)] requires adjustment when the 'reimbursement produced by the methods of determining costs' prove either inadequate or excessive . . . . The interim payments are merely monthly . . . estimates of costs, to which section 1395x(v)(1)(A) makes no reference." 536 F.2d at 352 n.11. *See also Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (2d Cir. 1973) (court rejected Secretary's claim that regulations implementing section 1395g were adequate to implement section 1395x(v)(1)(A) and noted distinction between section 1395g, which requires that interim payments be brought into agreement with reimbursable amount owed, and section 1395x(v)(1)(A) which requires that the Secretary provide a suitable retroactive adjustment where cost methods produce inadequate reimbursement).

The conclusions of the Third Circuit and the present decision of the District of Columbia Circuit are in direct contrast to the interpretation of section 1395x(v)(1)(A) discussed above. Both of these courts view section 1395x(v)(1)(A) as a procedural "book balancing" or "year-end accounting" provision.

In *Daughters of Miriam Center for the Aged v. Mathews*, 590 F.2d 1250 (3d Cir. 1978), the Third Circuit stated that section 1395x(v)(1)(A) mandates "retroactive adjustments in the *payments* received by providers, so as to bring the amounts paid to them on the basis of their monthly estimates in line with the amount

actually due them under the annual audit." 590 F.2d at 1258 n.23 (emphasis in original). The court claimed that the section was designed to ensure "regulations that would implement the scheme envisioned in § 1395g." *Id.*[5]

The District of Columbia Circuit's opinion below, like *Daughters of Miriam*, relied on the regulations implementing section 1395g to support its interpretation of section 1395x(v)(1)(A). (16a). The court referred to the regulations cited by *Georgetown* as "the accounting provisions promulgated pursuant to 42 U.S.C. § 1395x (v)(1)(A)(ii)." The regulations cited, however, while providing for retroactive adjustments to a provider's periodic payments, do *not* provide for the retroactive adjustment when the Secretary's method of determining costs proves inadequate, which is spoken of in clause (ii). *See Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d at 669; *Springdale Convalescent Center v. Mathews*, 545 F.2d at 954.

It is a "well-settled rule of statutory construction that all parts of a statute, if at all possible, are to be given effect." *Weinberger v. Hynson, Westcott and Dunning*, 412 U.S. 609, 633 (1973). The interpretation of both the Third Circuit and the District of Columbia Circuit renders section 1395x(v)(1)(A) superfluous, since section 1395g provides for the periodic estimated payments and adjustments that both circuits refer to in their respective discussions of section 1395x(v)(1)(A).

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[5] The issue in *Daughters of Miriam*, as in *Georgetown* was whether clause (ii) authorized the Secretary to engage in retroactive rulemaking. In rejecting that claim, the Third Circuit offered its opinion that clause (ii) provides merely for adjustments in a provider's periodic payments in keeping with section 1395g. 590 F.2d at 1258 n.23. The Court's interpretation of clause (ii) was unnecessary to its decision and thus is *dicta*.

II. CERTIORARI SHOULD BE GRANTED BECAUSE THIS COURT HAS NOT HAD THE OPPORTUNITY TO RESOLVE THIS UNSETTLED QUESTION OF LAW

The court below adopted its reading of section 1395x (v) (1) (A) in partial reliance on this Court's decision in *Bowen v. Georgetown University Hospital*, 109 S.Ct. 468 (1988). *See* (16a.) *Georgetown* did not address directly the correct construction of section 1395x(v) (1) (A) in circumstances such as those presented here. *See* 109 S. Ct. at 472 n.1. Rather, *Georgetown* dealt with the Secretary's authority to engage in across-the-board retroactive rulemaking. The Court addressed clause (ii) of section 1395x(v) (1) (A) only in the context of rejecting the Secretary's claim that clause (ii) granted him authority to engage in such retroactive rulemaking. *Id.*

In *Georgetown*, the Court specifically acknowledged that the circuit courts have not spoken with one voice on the scope of the retroactive corrective adjustment provision of section 1395x(v) (1) (A). 109 S.Ct. at 472 n.1. To the extent the Court's decision in *Georgetown* indicates how the Court might interpret section 1395x(v) (1) (A) in the circumstances presented here, it certainly can be read to support petitioners' arguments as readily as those of the Secretary.

In *Georgetown*, the Court stated, "clause (ii) directs the Secretary to establish a procedure for making case-by-case adjustments to reimbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases." 109 S. Ct. at 472. The Court also stated that "clause (ii) speaks in terms of adjusting the aggregate reimbursement amount computed by one of the *methods* of determining costs . . . [and] expressly contemplates corrective adjustments to the aggregate amounts of reimbursement produced pursuant to those methods." *Id.* at 473 (emphasis added). The Court's recognition that clause (ii) requires adjust-

ments to the aggregate amounts of reimbursement produced by particular cost methods is consistent with the approach adopted by the Ninth Circuit in *Regents v. Heckler* and at odds with the Third Circuit's decision in *Daughters of Miriam.*

The Court's citation in *Georgetown* to regulations adopted pursuant to section 1395g—in discussing the Secretary's authority pursuant to section 1395x(v)(1)(A)—created confusion regarding the Court's interpretation of section 1395x(v)(1)(A). 109 S. Ct. at 473. The court below seized on this *dicta* as evidence that the Court indicated in *Georgetown* its approval of the "adjustment to interim payments" interpretation of section 1395x(v)(1)(A). *See* 16a.

Petitioners respectfully submit that the Court's reference in *Georgetown* to regulations implementing section 1395g in its discussion of clause (ii) has created unnecessary and unintended confusion. First, the question whether the Third Circuit's "book balancing" approach to clause (ii) is appropriate was not before the Court in *Georgetown.* The Court specifically recognized contrary interpretations of clause (ii). 109 S.Ct. at 472 n.1. Although the Court expressly rejected the position that clause (ii) authorized retroactive rulemaking, it did not express an opinion as to the appropriateness of other circuit courts' interpretations of the statute. Certainly, the Court did not cite with either implicit or explicit approval the Third Circuit's holding that clause (ii) authorizes only a sort of year-end balancing of interim payments.

Second, it appears from the context of the Court's citation to the regulations dealing with annual adjustments to periodic payments that the Court was simply citing to the Secretary's previous claims regarding the meaning of clause (ii) to point out the inconsistency of his claim in *Georgetown* that clause (ii) authorized retroactive rulemaking. The Court was not asked to decide the mean-

ing of clause (ii), or to address the relationship between clause (ii) and section 1395g.

Third, the Court simply had no occasion to address the numerous cases that have rejected the argument that the regulations implementing section 1395g relieve the Secretary of responsibility to abide by section 1395x(v)(1)(A). Until the Court has a chance to address that issue directly, the *dicta* in *Georgetown*, and the D.C. Circuit's opinion in this case, will cause continued confusion in lower court interpretations of this complicated statute.

Confusion regarding the proper interpretation of clause (ii) allows the Secretary to continue his practice of adopting different interpretations of the section depending on his litigation strategy. *Compare Springdale Convalescent Center v. Mathews*, 545 F.2d at 954 (Secretary argued that clause (ii) gives him broad discretion to determine the period of retroactive application of certain regulations) *with Regents v. Heckler*, 771 F.2d at 1189 (Secretary argued section 1395x(v)(1)(A) required "no more than a year-end balancing of the books"); *and Medical Center Hospital v. Bowen*, 839 F.2d 1504, 1511 (11th Cir. 1988) (Secretary advanced several theories of his authority under clause (ii), ranging from the authority to make retroactive adjustments when cost methodology "has proven defective on a systemic basis" to the authority to make individual retroactive adjustments, but only pursuant to the "exceptions process"). Although the Secretary presumably will no longer argue that clause (ii) gives him the authority to engage in broad retroactive rulemaking, until the precise contours of the Secretary's obligations under the section are defined, the Secretary can be expected to continue to exploit the confusion to his benefit, and to the detriment of Medicare providers seeking what Congress mandated they be given: reimbursement for all reasonable costs necessarily incurred in the provision of Medicare benefits.

CONCLUSION

For the foregoing reasons, petitioners respectfully pray that the Court issue a writ of certiorari to review the judgment of the Court of Appeals for the District of Columbia Circuit.

Respectfully submitted,

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Dated: September 28, 1989

APPENDICES

APPENDICES

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APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

Argued May 5, 1989 Decided June 30, 1989

Nos. 88-5255 and 88-5256

HENNEPIN COUNTY, A body politic
organized under the laws of the
STATE OF MINNESOTA, *et al.*,
Appellants

v.

DR. LOUIS W. SULLIVAN, In his official
capacity as SECRETARY OF THE UNITED STATES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Appeal from the United States District Court
for the District of Columbia
(Civil Action No. 87-00366)

James M. Gaynor, Jr., with whom *H. Guy Collier* and *Amy E. Hancock* were on the brief, for appellants in No. 88-5255 and for appellees in No. 88-5256.

Gerard Keating, Attorney, Department of Health and Human Services, with whom *Stuart I. Silverman*, Attorney, Department of Health and Human Services, *Henry R. Goldberg*, Deputy Associate General Counsel for Litigation, Department of Health and Human Serv-

ices, *Craig R. Lawrence*, Assistant United States Attorney, *Jay B. Stephens*, United States Attorney, *Malcolm M.B. Sterrett*, General Counsel, and *Darrel J. Grinstead*, Acting Associate General Counsel, Department of Health and Human Services, Health Care Financing Division, were on the brief, for appellee/cross-appellant in Nos. 88-5255 and 88-5256.

Anthony J. Steinmayer and *Mark W. Pennak*, Attorneys, Department of Justice, also entered appearances for appellee in No. 88-5255 and for appellant in No. 88-5256.

Before: ROBINSON, EDWARDS and SILBERMAN, *Circuit Judges.*

Opinion for the Court filed by *Circuit Judge* EDWARDS.

EDWARDS, *Circuit Judge*: This case presents cross-appeals from a District Court decision denying Hennepin County and Hennepin County Medical Center (collectively "HCMC") immediate reimbursement under the Medicare statute, Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* (1982 & Supp. V 1987), but remanding the case to the Secretary of Health and Human Services[1] ("HHS") for further proceedings. In Count I of the complaint below, HCMC alleged that HHS unlawfully denied its request for an exemption (or "exception") from the limitations on reimbursable costs for medical education expenses in the 1980 cost reporting year. In Count II, HCMC alleged, in the alternative, that HHS unlawfully denied it a "retroactive corrective adjustment[]" for these same medical education expenses, pursuant to 42 U.S.C. § 1395x(v)(1)(A)(ii) (Supp. V 1987). The District Court granted summary judgment in favor of HHS on Count I, but granted summary judgment in favor of HCMC on Count II,

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[1] Louis Sullivan, the current Secretary of HHS, has been substituted as a defendant for Otis R. Bowen, who was Secretary at the time of the events giving rise to this litigation.

remanding the case to HHS to determine whether HCMC was entitled to a retroactive corrective adjustment. *See Hennepin County v. Bowen*, 689 F. Supp. 1 (D.D.C. 1988).

We affirm the judgment of the District Court as to Count I; we agree that HHS properly denied HCMC immediate reimbursement under applicable agency regulations. However, we reverse the summary judgment in favor of HCMC on Count II; since HCMC was not entitled to immediate reimbursement under Count I, it cannot be entitled to retroactive reimbursement for these same claims under the same regulation by which it was denied reimbursement in the first instance. Accordingly, we reverse the trial court's remand of the case to HHS for further proceedings.

There cannot be a retroactive corrective adjustment here because it is clear that, under existing, lawful agency regulations, HCMC was not entitled to any exemption from the limitation on reimbursable costs for medical education expenses. In other words, HCMC has received all that it was due under the law. We reject HCMC's sugestion that 42 U.S.C. § 1395x(v)(1)(A)(ii) should be read to compel the Government, after the fact, to consider whether, as a matter of "fairness," claimants should be awarded something more than lawful regulations required. This would amount to a form of retroactive rulemaking that was specifically rejected by the Supreme Court in *Bowen v. Georgetown Univ. Hosp.*, 109 S. Ct. 468 (1988). Accordingly, we affirm in part and reverse in part the judgment of the District Court.

I. Background

A. *Statutory and Regulatory Framework*

The Medicare statute, Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* (1982 & Supp. V 1987), through a complex reimbursement process, *see*

Tallahassee Memorial Regional Medical Center v. Bowen, 815 F.2d 1435, 1438-40 (11th Cir. 1987), *cert. denied*, 108 S. Ct. 1573 (1988), furnishes providers of health care services with reimbursements for certain costs associated with the treatment of the aged and disabled. At the time of the events leading to this litigation, the Medicare statute provided that a health care provider was entitled to reimbursement for the lesser of the reasonable costs of the services as defined under 42 U.S.C. § 1395x(v), or the provider's customary charge for such services.[2] 42 U.S.C. § 1395f(b)(1) (1982). The statute defined "reasonable costs" as those "cost[s] actually incurred, excluding therefrom any part of incurred cost[s] found to be unnecessary in the efficient delivery of needed health services," 42 U.S.C. § 1395x(v)(1)(A); it authorized the Secretary of HHS to establish the methods for determining costs, *id.*; and it granted the Secretary broad rulemaking authority, *see id.* Pursuant to this broad authority, the Secretary has established cost limits for reimbursable routine costs, 42 C.F.R. § 405.460; 39 Fed. Reg. 20,164 (June 6, 1974),[3] and a procedure for determining these cost limits, *see id.* § 405.460(b)(3).

The Secretary also enacted two basic mechanisms for adjustment of cost limits in cases where the general rules do not adequately reimburse the health care pro-

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[2] Effective October 1, 1983, a new reimbursement formula went into effect under 42 U.S.C. § 1395ww(d) (Supp. V 1987), known as the prospective payment system. This new system provides for prospective reimbursement to providers on the basis of predetermined rate for each "discharge" according to the patient's diagnosis.

[3] In 1986, the Medicare regulation were redesignated in the *Code of Federal Regulations*, and 42 C.F.R. § 405.460 is now numbered 42 C.F.R. § 413.30. Because the events in this case took place well before this redesignation, we cite to this regulation in its original form for convenience and for consistency with the lower court decision. *See Hennepin County*, 689 F. Supp. at 3 n.5.

vider's reasonable costs. First, a provider may seek an exemption from the cost limits under one of the enumerated situations in 42 C.F.R. § 405.460(f)—for example, when excess expenses are attributable to "extraordinary circumstances," *see id.* § 405.460(f)(2). An exception is allowed only if the costs are

> reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.[4]

Id. § 405.460(f). In this case, HCMC sought reimbursement under section 405.460(f)(4), which allows an exception for health care providers operating an approved graduate medical education program if the provider

> can demonstrate that, if compared to other providers in its group, it incurs increased costs for items or services covered by limits under this section because of its operation of an approved education program.

Id. § 405.460(f)(4).

The additional costs generated by a graduate medical education program include both "direct" and "indirect" costs, but 42 C.F.R. § 405.460(f)(4) refers only to "indirect costs." "Direct costs" consist of the actual costs of operating an approved educational program, such as resident stipends and teaching costs. "Indirect costs" consist of those operating expenses which are generally higher in teaching hospitals than in non-teaching hospitals. HCMC sought additional reimbursement for indirect costs associated with increased administrative expenses attributable to educating and supervising the residents in the hospital; these expenses included items such

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[4] The fiscal intermediary, usually a private insurance company, is the statutorily-provided agent of the Secretary with whom each health care provider files its annual cost report for review of the reimbursement claims. 42 U.S.C. § 1395h (1982 & Supp. V 1987).

as the additional ward clerk and nurse time spent instructing residents on hospital's procedures. Brief for HCMC at 11-12.

Wholly apart from the regulations covering exemptions from the limitations on reimbursable costs is the provision in 42 U.S.C. § 1395x(v)(1)(A)(ii), which directs the Secretary to establish regulations to

> provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

42 U.S.C. § 1395x(v)(1)(A)(ii). As is clear from the terms of the statute, Congress left the task of delineating the scope of "suitable retroactive corrective adjustments" entirely to the Secretary of HHS. Pursuant to this statutory mandate, the Supreme Court noted in *Georgetown Hosp.* that the Secretary promulgated "regulations . . . immediately after enactment of the Medicare Act establish[ing] a mechanism for making retroactive corrective adjustments" through 42 C.F.R. §§ 405.451(b)(1), 405.454(a), (f) (1983). *See Georgetown Hosp.*, 109 S. Ct. at 473. As the Court elaborated, "[t]hese regulations provide for adjusting the amount of interim payments received by a provider, to bring the aggregate reimbursement into line with the provider's actual reasonable costs." *Id.* And, to make the point more forceful, the Court added, "[42 C.F.R. §§ 405.451(b)(1), 405.454(a), (f)] are the only regulations that expressly contemplate the making of retroactive corrective adjustments." *Id.*

Based on these dual avenues for relief, HCMC makes two alternative applications for reimbursement. In Count I, HCMC argues that it is entitled to an *exception* pursuant to 42 C.F.R. § 405.460(f); and, alternatively, in Count II, HCMC maintains that it is entitled to a *retro-*

active corrective adjustment under 42 U.S.C. § 1395x (v) (1) (A) (ii).

B. *The Facts of this Case*

HCMC is a teaching hospital with a large graduate medical education program. With 242 residents and 425 beds, it has what it claims is an unusually large program, teaching at a ratio of one resident for every 1.8 beds; in contrast, the average urban hospital with a comparable number of beds has one resident for every 8.1 beds. Because of this large medical education program, HCMC claims its 1980 cost year operating expenses exceeded the Medicare established routine cost limits.

On January 13, 1982, HCMC requested an exception to, and an upward adjustment of, its reimbursable cost limit for its 1980 cost year.[5] The Health Care Financing Administration ("HCFA"), the branch of HHS responsible for handling such requests, denied HCMC's request on March 18, 1982, on the ground that HCMC had failed to document its request. On July 23, 1982, HCMC submitted a second exception request, asserting that pursuant to 42 C.F.R. § 405.460(f) (4), it was entitled to reimbursement for atypical indirect costs attributable to its approved graduate medical education program.

HCMC supported its second request for exception with information from a 1980 HCFA Study that investigated the effect of medical education programs on routine costs. One of the conclusions in the Study was that teaching hospitals are generally more costly than other hospitals. The Study found a direct linear relationship between the ratio of residents or interims per bed and the additional costs incurred by the hospital. In light of these

[5] Originally, HCMC claimed that it was entitled to reimbursement for $928,513; however, HCMC now seeks reimbursement for only $742,284 in indirect costs attributable to operating its graduate medical education program.

findings, HCFA adopted a "medical education cost adjustment factor," called a "teaching adjustment factor," effective for cost reporting years beginning *on or after July 1, 1980—i.e.*, beginning with HCMC's *1981* cost year. This teaching adjustment factor provides for an increase in a teaching hospital's cost limits by 4.7% for each increase of .10 in the hospital's ratio of full-time or equivalent interns and residents to its bed size.

HCMC states that it relied on the HCFA Study rather than individualized information gathered independently because it "is nearly impossible . . . to identify the precise amount of increased . . . time [spent by various departments] attributable to HCMC's operation of large graduate medical education programs." Brief for HCMC at 11. In order to quantify its indirect costs in a way that would satisfy the requirements of 42 C.F.R. § 405.460(f)(4), HCMC claims that it would have to spend over $500,000 to conduct a study of internal data, and even then it might not be able to generate data that would be usable regarding the separation of costs between medical education and patient care functions. *See* Reply Brief for HCMC at 4-5.

HCFA denied HCMC's requested exception a second time, stating that HCMC had failed to demonstrate and specifically identify those routine costs associated with its medical education program that were atypical when compared to the costs of similarly classified hospitals and were attributable to HCMC's graduate medical education program. Furthermore, HCFA stated that the use of the cost adjustment factor applied to the limits for the 1980 cost year would result in a cost limit exception that was too high.

Following HCFA's second denial of its request, HCMC engaged the consultants Touche Ross & Co. to assist in demonstrating that the hospital had incurred atypical routine operating expenses attributable to its medical

education program. Touche Ross produced its own Study, which applied the teaching adjustment factor of the HCFA Study to HCMC's 1980 expenses, and then adjusted the amount downwards to reflect the amount that had already been reflected in the HHS payments to HCMC under the 1980 limits. Using this formula, the Touche Ross Study concluded that HCMC was underreimbursed for atypical indirect medical education costs by $742,284 for the 1980 cost year.

Using the Touche Ross Study as evidence, HCMC appealed HCFA's determination to the Provider Reimbursement Review Board ("PRBB"), pursuant to 42 U.S.C. § 1395oo(a) (1982 & Supp. V 1987). After a hearing, the PRRB also denied the request for an exception. In a decision dated December 16, 1986, the PRRB agreed that HCMC "did not specifically identify the claimed excess atypical indirect costs as required by 42 C.F.R. 405.460(f)." *See Hennepin County Medical Center v. Blue Cross & Blue Shield Ass'n*, Provider Reimbursement Review Board Hearing Decision No. 85-904, slip op. at 4 (Dec. 16, 1986), *reprinted at* Appendix ("A.") 15, 18. Moreover, the PRRB found that HCMC did not meet the specific "requirements of 42 C.F.R. § 405.460 (f)(4) because it ha[d] not demonstrated that it incurred increased costs for items or services over those incurred by comparable providers from the operation of an approved education program specified in 42 C.F.R. 405.421." A. 18. The PRRB rejected the argument that the HCFA Study was adequate to demonstrate the need for reimbursement under 42 C.F.R. § 405.460(f)(4) because the "routine cost limit methodology [this Study] adopted for cost reporting periods beginning on or after July 1, 1980 adjusted the limits for indirect approved education costs but did not specifically identify the costs." A. 18-19.

Pursuant to 42 U.S.C. § 1395oo(f)(1) (Supp. V 1987), HCMC appealed the PRRB decision to the District Court

on February 13, 1987. HCMC argued that it was entitled to an immediate medical education reimbursement under 42 C.F.R. § 405.460(f) in Count I, or to a retroactive adjustment under 42 U.S.C. § 1395x(v)(1)(A)(ii) in Count II. The District Court rejected HCMC's argument as to Count I, but reserved and remanded to the PRRB for further consideration as to Count II.

The District Court relied on the reasoning of the Eighth Circuit in a case with nearly identical facts, *St. Paul-Ramsey Medical Center v. Bowen*, 816 F.2d 417 (8th Cir. 1987), in disposing of Count I. The District Court found that it was entirely reasonable for the Secretary to "require the provider to furnish specific data regarding the manner in which HCMC's actual indirect costs associated with its graduate medical education program exceeded the cost limits," *Hennepin County*, 689 F. Supp. at 6, in light of the Eighth Circuit's decision in *St. Paul-Ramsey* and "in keeping with [the D.C.] Circuit's indications of the high degree of deference accorded the Secretary in interpreting the Medicare statute." *Id.* Thus, the Court granted summary judgment for HHS on Count I.

However, on Count II, the District Court departed from the reasoning of the court in *St. Paul-Ramsey*. To the extent that *St. Paul-Ramsey* held that HHS had a duty to retroactively correct *every* pre-1981 disbursement made under 42 C.F.R. § 405.460(f) without an individual showing of need, the District Court recognized that *St. Paul-Ramsey* violated the rule against retroactive rulemaking as set forth by this circuit in *Georgetown Univ. Hosp. v. Bowen*, 821 F.2d 750 (D.C. Cir. 1987). *See* 689 F. Supp. at 6-7.[6] Nevertheless, the District Court rejected the HHS argument that mandating a retroactive reassess-

[6] This court's decision in *Georgetown Univ. Hosp.* was affirmed by the Supreme Court after the trial court's opinion had issued in this case. *See Bowen v. Georgetown Univ. Hosp.*, 109 S. Ct. 468 (1988).

ment of HCMC's claim would amount to retroactive rulemaking. Instead, the court held that

> section 1395x(v)(1)(A)(ii) *requires* a retroactive corrective adjustment if a *particular* provider demonstrates that *it* was reimbursed inadequately. . . . [T]he Secretary must grant a retroactive cost adjustment if an individual provider demonstrates that it experienced reasonable expenses in excess of the cost limits for a given year. The Court determines that this does not amount to a broad retroactive rule in contravention of *Georgetown University* because the Secretary must review each provider's case individually.

689 F. Supp. at 7 (emphasis in original). Applying this rationale to the immediate facts, the trial court reasoned that

> the parties agree that health care providers with graduate medical education programs experience higher operating costs. In light of this fact, the Secretary implemented the teaching adjustment factor. While the Secretary is precluded from retroactively applying the regulation across the board, the Secretary's regulation amounts to a recognition that the methods of setting the cost limits for providers with graduate education programs were inadequate and providers may have been compensated inadequately. The Secretary, therefore, must consider whether HCMC, itself, suffered inadequate compensation.

Id. at 7-8. The District Court thus granted summary judgment for HCMC on Count II and remanded to the PRRB for further consideration.

A little over two months later, the District Court issued a clarification order, *see id.* at 8-9, to make clear that the only avenue through which HCMC could be granted substantive relief was under HHS regulations promulgated in furtherance of 42 U.S.C. § 1395x(v)(1)

(A)(ii). The clarification order stated that, even in consideration of its retroactive application, "the exclusive means for HCMC to proceed is pursuant to 42 C.F.R. § 405.460(f); and . . . HCMC bears the burden of proof under the regulatory scheme." *Id.* at 9.

HCMC appeals the District Court decision on Count I, alleging that the HCFA and Touche Ross Studies provided sufficient evidence for a finding of a medical education costs exception. Specifically, HCMC alleges that it was an abuse of discretion for HHS to find the Studies to be inadequate when the individualized data HHS required was impossible to produce. HHC appeals the decision on Count II on two grounds: first, HHS claims that it is illogical to mandate retroactive consideration of a decision simultaneously held to be reasonable; and, second, HHS argues that the trial court's decision would require the agency to engage in prohibited retroactive rulemaking.

II. Analysis

Our review in this case, like that of the District Court, is limited to determining whether, on the record as a whole, the PRRB's decision is supported by substantial evidence.[7] Our review proceeds as if this case were an immediate appeal from a decision reached after an administrative hearing on the record. The District Court's decision is not entitled to any particular deference. *Biloxi Regional Medical Center v. Bowen*, 835 F.2d 345,

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[7] Under the Act, the district court's review of PRRB decisions is governed by the scope of review provisions of the Administrative Procedure Act, 5 U.S.C. § 706. *See* 42 U.S.C. § 1395oo(f)(1); *Biloxi Regional Medical Center v. Bowen*, 835 F.2d 345, 348 n.13 (D.C. Cir. 1987). Because the PRRB's decision is the result of "an agency hearing provided by statute," a reviewing court must set aside PRRB decisions found to be "unsupported by substantial evidence" after the court has reviewed the whole record. 5 U.S.C. § 706(2)(E) (1982). *See Monsour Medical Center v. Heckler*, 806 F.2d 1185, 1190 (3d Cir. 1986), *cert. denied*, 482 U.S. 905 (1987); *Biloxi*, 835 F.2d at 348 n.13.

348-49 (D.C. Cir. 1987); *Walter O. Boswell Memorial Hosp. v. Heckler*, 749 F.2d 788, 790 n.2 (D.C. Cir. 1984); *see also Regents of the Univ. of California v. Heckler*, 771 F.2d 1182, 1187 (9th Cir. 1985) ("[W]e review the Secretary's action under the same standard as did the district court.").

A. *Count I: The Medical Education Costs Exception*

HCMC admits that the "dispute in this case . . . centers not on whether HCMC had increased costs as a result of its large medical education programs, but rather on the adequacy of HCMC's demonstration that its routine costs in excess of the limits were attributable to [these programs]—in other words, whether HCMC has 'separately' identified those costs." Brief for HCMC at 19. On the record of this case, we agree with the District Court's judgment upholding the PRRB conclusion that HCMC did not precisely identify its costs. Indeed, HCMC itself spends a considerable portion of its brief arguing that it *cannot* identify these costs with any precision, because of the difficulty of parsing time allocation of indirect costs. Thus, we affirm the District Court's finding that the PRRB properly denied HCMC a medical education costs exception under 42 C.F.R. § 405.460(f)(4).

HCMC's argument rests primarily on the fact that, because the HCFA Study itself recognized that precise data was unproducible, HCMC's reliance on the HCFA Study was therefore "reasonable." However, this argument begs what HCMC admits is the fundamental question in this case: whether HCMC submitted sufficient evidence to demonstrate "separately identified" excess costs incurred because of its medical education program "if compared to other providers in its group." 42 C.F.R. § 405.460(f).

It is irrelevant that the HCFA Study noted how difficult it would be to quantify a medical education excep-

tion; it is also irrelevant that HHS prospectively altered its regulations in light of this difficulty. If HCMC means to suggest that, because of this difficulty, the refusal to apply the Study's findings to pre-1981 claims was *prima facie* arbitrary and capricious, we reject this contention. To embrace such a rule would be to discourage agencies from reconsidering their regulations in light of new data for fear of being forced to apply new regulations retroactively. This we will not do, for there is nothing inherently arbitrary or capricious about an agency's decision to apply new data prospectively only.

Furthermore, and more importantly, HCMC concedes that it has challenged neither the legality of the standard under 42 C.F.R. § 405.460(f), nor its applicability to this case. Indeed, at oral argument, counsel for HCMC acknowledged that this regulation was in place and lawful, and that it had been consistently applied by the agency to claims of the sort at issue here. It is clear that HCMC did not qualify for an exemption under the regulation; therefore, no relief is due under the applicable exceptions to the limitations on reimbursable costs. It does not matter that the regulation covering post-1980 claims is more favorable to providers. What does matter is that HCMC did not satisfy the *lawful* regulation covering 1980 claims.

It may be true that HCMC's reliance on the HCFA Study was "reasonable," but this does not mean that HCFC's refusal to accept it as sufficient to justify a 42 U.S.C. § 405.460(f)(4) exception was arbitrary or unreasonable. Indeed, HHS does not argue that this reliance was not reasonable, but only that these Studies were not hospital-specific enough to meet the additional requirements of proving an *individual* exception to the cost limits. Put another way, this Study offers the type of information required for formulation of a new general regulation rather than that required to meet the specific needs of the original particular exception under 42 C.F.R.

§ 405.460(f). While it may not have been unreasonable for HCMC to interpret the Study data otherwise, HCMC has made absolutely no showing that HHS' interpretation was not reasonable.[8]

Accordingly, we affirm the District Court's judgment on Count I. We reject HCMC's argument that it was unlawful for HHS to reject its petition for an immediate exception under 42 C.F.R. § 405.460(f)(4). There is substantial evidence on the record as a whole to support the PRRB finding that HCMC had not "separately identified" its costs warranting a claim for a medical education exception, and the decision was neither arbitrary, capricious, nor an abuse of discretion.

B. *Count II: The Retroactive Corrective Adjustment*

On the claim arising under Count II, we reverse the judgment of the District Court. On the facts of this case, we hold that the retroactive adjustment provision of 42 U.S.C. § 1395x(v)(1)(A)(ii) provides no basis for a remand to the PRRB. There can be no retroactive re-

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[8] HCMC complains that HHS did not give providers any guidance as to what *would* be sufficient data to meet the HHS standard for a medical education exception. However, HCMC disregards the concrete information HHS did provide. For example, HHS states that 42 C.F.R. § 405.460(f)(4) does not require providers to precisely quantify its indirect costs with "mathematical exactitude," but only that providers supply some specific individual data to demonstrate alleged entitlement to an upward adjustment to the 1980 cost limits. Had HCMC provided any such information, HHS claims, HHS would have applied a "rule of reason" to this information when deciding on HCMC's entitlement. Brief for HHS at 47-48. HCMC never attempted to provide any such individualized information. For example, HCMC could have estimated *average* additional nurse time spent on rounds when a nurse is also instructing a medical student. Similarly, HCMC never attempted to show that its expenses were higher "compared to other providers in its group" 42 C.F.R. § 405.460(f)(4), which would have provided additional particularity. Instead, HCMC overlooked what clear guidelines HHS offered.

adjustment here because it is clear, as we have explained, that under existing, lawful methodology, HCMC failed to demonstrate that it was entitled to an exception from routine reimbursement cost ceilings. Therefore, HCMC has already received everything to which it is entitled. Section 1395x(v)(1)(A)(ii) is not a vehicle through which Medicare providers may get a "second bite at the apple" on claims for exceptions to limitations on reimbursable costs.

The District Court apparently believed that, even though HCMC could not succeed on its claim for reimbursement under the applicable standard, it could use section 1395x(v)(1)(A)(ii) to require HHS to reassess the same claim under precisely the same standard that had already proven unsuccessful. However, both counsel acknowledged at oral argument that this rationale could not support a judgment for HCMC. We agree, because the Supreme Court made clear in *Georgetown Hosp.* that the regulations promulgated pursuant to the statutory retroactive corrective adjustment provision of 42 U.S.C. § 1395x(v)(1)(A)(ii) were wholly part and distinct from the substantive regulation considered in Count I of this litigation. Unlike the medical costs exception regulation, the regulations promulgated pursuant to the retroactive adjustment provision permit adjustments only to the *aggregate amounts* of reimbursement pursuant to valid regulatory methods; they do not permit changes in the *methods* used to compute costs. *See Georgetown Univ.*, 109 S. Ct. at 473 & n.2 (characterizing 42 C.F.R. §§ 405.451(b)(1), 405.454(a), (f)).

Furthermore, we reject HCMC's suggestion that 42 U.S.C. § 1395x(v)(1)(A)(ii) should be read to compel the Government, after the fact, to consider whether, as a matter of "fairness," claimants should be awarded something more than lawful regulations required. As noted above, the Court in *Georgetown Univ.* held that the point of the accounting provisions promulgated pur-

suant to 42 U.S.C. § 1395x(v)(1)(A)(ii) is to ensure that petitioners receive what they are actually *due* under the applicable regulation, no more and no less. Thus, the clause does not authorize a *post hoc* reassessment of the efficacy of the relevant standard, only of the calculations made pursuant to that standard. Requiring a retroactive reassessment here would call for precisely such a *post hoc* reassessment, and cannot be sustained.[9]

III. Conclusion

Because we find that HHS properly denied HCMC an immediate medical education costs exception under 42 C.F.R. § 405.460(f)(4), we affirm the District Court's ruling on Count I. The record clearly supports the PRRB denial of such an exception to HCMC.

However, because HCMC cannot be granted claims retroactively that were not warranted in the first instance, we reverse the District Court's remand to the PRRB on Count II. We grant summary judgment on behalf of HHS on this issue as well.

Judgment accordingly.

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[9] In this regard, this case is completely distinguishable from this circuit's recent decision in *Beverly Hosp. v. Bowen*, 872 F.2d 483 (D.C. Cir. 1989). *Beverly Hosp.* involved a substantive agency regulation that was void *ab initio*, *see* 872 F.2d at 485, whereas the case before us today involves an indisputably valid regulation.

APPENDIX B

UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

Civ. A. No. 87-0366.

HENNEPIN COUNTY and HENNEPIN COUNTY MEDICAL CENTER,
Plaintiffs,

v.

OTIS R. BOWEN, M.D.,
Defendant.

March 17, 1988

On Motion For Reconsideration and Clarification June 1, 1988

MEMORANDUM OPINION

THOMAS F. HOGAN, District Judge.

Plaintiffs bring suit under Part A of Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.*, ("the Act"), commonly known as the Medicare statute. In Count I of the complaint, plaintiffs allege that defendant unlawfully denied an exception to plaintiffs' cost limits. In Count II of the complaint, plaintiffs maintain that defendant unlawfully denied them a retroactive cost adjustment. Presently before the Court are the parties' cross-motions for summary judgment. In consideration of

the motions, the oppositions thereto, oral argument by counsel, and the entire record of the case, the Court shall deny plaintiffs' motion for summary judgment as to Count I and grant summary in favor of defendant as to Count I. The Court shall, however, grant plaintiffs' motion for summary judgment as to Count II and remand the case to the Secretary for further proceedings in accordance with the following opinion.

FACTUAL AND STATUTORY BACKGROUND

Plaintiffs, Hennepin County and Hennepin County Medical Center (collectively, "HCMC"), challenge the decision of the Provider Reimbursement Review Board ("PRRB") denying HCMC's request for an exception to the medicare routine cost limits for its 1980 cost reporting year for atypical medical education costs.[1] Plaintiffs also contest the refusal of the Secretary of the Department of Health and Human Services (the "Secretary") to grant a retroactive corrective adjustment for HCMC's 1980 cost year.

The Medicare statute furnishes providers of health care services with reimbursements for certain costs associated with the treatment of the aged and disabled.[2]

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[1] The Secretary formulates routine cost limits for each fiscal year. 42 U.S.C. § 1395x(v)(1)(A). HCMC's fiscal year is the same as the calendar year. The cost limits promulgated by the Secretary for cost reporting periods beginning on or after July 1, 1979 applied to HCMC's cost reporting year beginning January 1, 1980 and ending December 31, 1980. Likewise, the cost limits promulgated for cost reporting periods beginning on or after July 1, 1980 apply to HCMC's cost reporting period beginning January 1, 1981 and ending December 31, 1981. For convenience, these periods will be referred to as the "1980 cost year" and the "1981 cost year," respectively.

[2] The Medicare reimbursement process is quite intricate and the Court need not delve into its complexities. For a thorough review of the technical aspects of reimbursement *see Tallahassee Memorial Regional Medical Center v. Bowen*, 815 F.2d 1435, 1438-40 (11th Cir. 1987), *petition for cert. filed*, Sept. 2, 1987.

Specifically, the health care provider shall be reimbursed for the lesser of the reasonable costs of the services, as defined under section 1395x(v), or the provider's customary charge for such services. 42 U.S.C. § 1395f(b)(1).[3] "Reasonable costs" are the "cost[s] actually incurred, excluding therefrom any part of incurred cost[s] found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v)(1)(A). The statute authorizes the Secretary to establish the methods for determining costs. *Id.* In defining the rather broad contours of the Secretary's rulemaking authority, the statute states that regulations promulgated by the Secretary

> may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services . . .

42 U.S.C. 1395x(v)(1)(A).[4]

Pursuant to this authority, the Secretary established cost limits for reimbursable routine costs. *See* 42 C.F.R.

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[3] Congress enacted a new reimbursement formula, the prospective payment system, which became effective October 1, 1983. 42 U.S.C. § 1395ww(d). This system provides for prospective reimbursement on the basis of a predeterminted, specific rate for each "discharge," according to the patient's diagnosis (a "diagnosis related group" or "DRG").

[4] Originally, the Secretary lacked the authority to establish cost limits. In response to a perceived problem with inefficiencies in health care institutions, Congress provided the Secretary with the power to set cost limits. Social Security Amendments of 1972, Pub. L. No. 92-603, § 223(a); *see* S. Rep. No. 1230, 92d Cong., 2d Sess. 186-88 (1972), U.S. Code Cong. & Admin. News 1972, p. 4989.

§ 405.460; 39 Fed.Reg. 20,164 (June 6, 1974).[5] The Secretary established a procedure for determining the cost limits whereby "[p]rior to the beginning of a cost period to which revised limits will be applied, HCFA [the Health Care Financing Administration] will publish a notice in the *Federal Register*, establishing cost limits and explaining the basis on which they were calculated." 42 C.F.R. § 405.460(b)(3). The Secretary first promulgated a regulation and schedule of limits on the costs of general inpatient hospital routine services in 1974.[6]

Basically, there are two avenues for adjusting cost limits which do not adequately reimburse the health case provider's reasonable costs. First, a health care provider may seek an exception to the cost limits in certain circumstances. 42 C.F.R. § 405.460(f). An exception will be made

> only to the extent the costs are reasonable, attributable to the circumstance specified, separately identified by the provider, and verified by the intermediary.

Id. The circumstance implicated in this case involves an exception for health care providers operating an approved graduate medical education program.[7] The Secretary grants such a health care provider an exception if it

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[5] In 1986, the Medicare regulations were redesignated in the Code of Federal Regulations. The regulation pertinent to this case, 42 C.F.R. § 405.460, now is designated 42 C.F.R. § 413.30. For convenience, however, the Court shall cite to the regulation in its original form as 42 C.F.R. § 405.460.

[6] The Secretary updated the cost limits annually through 1981. The limits are no longer updated due to the prospective payment system which went into effect in October 1983. For cost reporting periods beginning on or after July 1, 1979, the applicable group limits were published at 44 Fed. Reg. 31,806 (June 1, 1979).

[7] Other than the situation of a provider opearting a graduate medical education program, the regulation defines other circumstances in which the Secretary will consider granting an exception

> can demonstrate that, when compared to other providers in its group, it incurs increased costs for items or services covered by limits under this section because of its operation of an approved education program.

Id. § 405.460(f)(4).[8] The second means for seeking an adjustment to a provider's reimbursement is by invoking the retroactive corrective adjustment provision in section 1395x(v)(1)(A)(ii) which specifically directs the Secretary to establish regulations to

> provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

Id. In this case, HCMC initially argues that it is entitled to an exception pursuant to 42 C.F.R. § 405.460(f). Alternatively, HCMC maintains it is entitled to a retroactive corrective adjustment under 42 U.S.C. § 1395x(v)(1)(A)(ii).

HCMC is a teaching hospital with a large graduate medical education program. HCMC claims that its 1980 cost year operating expenses exceeded the Medicare es-

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to a given provider's cost limits. *See* 42 C.F.R. 405.460(f). For example, the regulation provides an exception for the case of a hospital incurring excessive expenses attributable to extraordinary circumstances.

[8] The costs associated with a health care provider which also has a medical education program consist of two components. First, "direct" costs consist of the costs of actually operating an approved educational program, i.e., resident stipends, teaching costs. Second, "indirect" costs consist of those other operating costs which are generally higher in hospitals with a medical education program as compared with hospitals without medical education programs. The exception set forth at 42 C.F.R. § 405.460(f)(4) is oriented towards these indirect costs. Only the indirect costs are at issue here.

tablished routine cost limits. Originally, HCMC claimed that it was entitled to reimbursement for $928,513.00. Presently, plaintiff seeks reimbursement for $742,284.00 for indirect costs attributable to operating its graduate medical education program. On January 13, 1982, plaintiffs requested an exception to, and an upward adjustment of, its hospital cost limit applicable for its 1980 cost year. Administrative Record ("Record") 541-42. The Health Care Financing Administration [HCFA] denied HCMC's request on March 18, 1982, stating that HCMC had failed to document its request. Record 547. On July 23, 1982, HCMC submitted a second exception request asserting that pursuant to 42 C.F.R. § 405.406 (f) (4) HCMC was entitled to reimbursement for atypical indirect costs attributable to its approved graduate medical education program. Record 543-44. The second request quantified its exception by utilizing a 1980 HCFA study ("HCFA study") which investigated the effect of medical education programs on routine costs.[9] HCFA again denied the hospital's requested exception stating that the provider had failed to demonstrate and specifically identify those routine costs associated with its medical education program that were atypical when compared to the costs of similarly classified hospitals. Furthermore,

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[9] In 1980, HCFA conducted a study of hospital providers to determine whether a relationship exists between routine operating costs and the size of the provider's teaching programs. *See* Record 594-610. One of the study's conclusions was that teaching hospitals are generally more costly than other hospitals. Record 602. The study found a direct linear relationship between the ratio of residents/interns per bed and the additional cost incurred by the hospital. *Id.* In consideration of the findings, HCFA adopted a "medical education cost adjustment factor" ("teaching adjustment factor") effective for cost reporting years beginning on or after July 1, 1980. 45 Fed. Reg. 41,868 (June 20, 1980). The teaching adjustment factor provides for an increase in a teaching hospital's limit by 4.7% for each increase of .10 in the hospital's ratio of full-time equivalent interns and residents to its bed size. 45 Fed. Reg. at 41,874.

the HCFA stated that the use of the cost adjustment factor applied to the limits for the 1980 cost year would result in a cost limit exception amount that was too high. Record 546, 548.

Following the HCFA's second denial of its exception request, HCMC had engaged Touche Ross to assist in demonstrating that the hospital had incurred atypical routine operating expenses attributable to its medical education program. The Touche Ross study concluded that HCMC was under-reimbursed for atypical indirect medical education costs by $742,284.[10] HCMC utilized the Touche Ross study when it appealed the HCFA's determination to the PRRB. After a hearing, the PRRB denied the exception request. Record 7-13 (decision of PRRB dated December 16, 1986); Record 126-283 (transcript of August 27, 1986 hearing before the PRRB). The PRRB concluded that

> [t]he Provider did not specifically identify the claimed excess atypical indirect costs as required by 42 CFR 405.460(f). An upward adjustment to the limits is permitted under 42 CFR 405.460(f) only to the extent that the costs are reasonable, attributable to the circumstances described, specifically identified by the Provider, and verified by the Intermediary. In addition, the Provider has not met the requirements of 42 CFR 405.460(f)(4) because it has not demonstrated that it incurred increased costs for items or services over those incurred by comparable providers from the operation of an approved education program specified in 42 CFR 405.421.

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[10] The Touche Ross study used the teaching adjustment factor to quantify HCMC's reasonable atypical medical education costs. Because the cost limits governing HCMC for their 1980 cost year included some reimbursement for indirect costs, the Touche Ross study analyzed the data used to construct the 1980 cost year limits to qauntify the amount of indirect medical education costs that already were reflected in those limits. Record 207-11; 511-16.

> The routine cost limit methodology adopted for cost reporting periods beginning on or after July 1, 1980 adjusted the limits for indirect approved education costs but did not specifically identify the costs. Thus, that methodology does not meet the explicit requirements of 42 CFR 405.460(f)(4).

Record 10-11. HCMC appealed the PRRB's decision to this Court on February 13, 1987. Count I of the complaint alleges that the Secretary arbitrarily and capriciously denied HCMC's request for an exception to the limits governing HCMC's 1980 cost year. Count II of the complaint alleges that the statute requires that the Secretary grant a retroactive corrective adjustment to its reimbursement for the 1980 cost year because the Secretary's method for determining the cost limits for that year produced an inadequate reimbursement.

DISCUSSION

I. THE SECRETARY DID NOT ARBITRARILY AND CAPRICIOUSLY DENY HCMC'S REQUEST FOR AN EXCEPTION TO THE LIMITS GOVERNING HCMC'S 1980 COST YEAR.

Under 42 C.F.R. § 405.460(f), a provider operating a graduate medical education program qualifies for an exception to the cost limits for a given year only upon demonstrating that the costs in excess of the cost limits are (1) reasonable; (2) attributable to the operation of an approved medical education program; (3) separately identifiable; (4) verified by the intermediary; and (5) higher than the costs incurred by other providers in its group. 42 C.F.R. § 405.460(f)(4). The basic issue of contention between the parties is whether HCMC separately identified the excessive costs attributable to the operation of the medical education program.

The Secretary found that HCMC failed to identify specifically those excessive costs attributable to the medical

education program. Furthermore, the Secretary found that plaintiff had failed to establish that it incurred increased costs for items or services over those incurred by comparable providers with medical education programs. HCMC utilized the HCFA study which established that hospitals with graduate medical education programs incur higher costs than those providers without a medical education program. *See, supra* note 9 (discussing HCFA study and conclusions). This study formed the basis for the promulgation of the medical education cost adjustment factor ("teaching adjustment factor") effective for cost reporting years beginning July 1, 1980. *See* 45 Fed. Reg. 41868 (June 20, 1980). Plaintiff claims that it utilized the study and quantified its findings to HCMC specific information.[11] Plaintiff maintains that to conduct a study to specifically identify those costs associated with the indirect costs of running a graduate medical education program would have been cost prohibitive.[12]

The Medicare statute directs the Court to review the Secretary's determinations consistent with the procedures of the Administrative Procedure Act. 42 U.S.C. § 1395*oo* (b). In this case, the arbitrary and capricious standard applies. 5 U.S.C. § 706. This Circuit has ruled on a num-

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[11] At the PRRB hearing, Kenneth Stocke, a partner at Touche Ross, testified as to the mechanics of quantifying the data. Touche Ross used the specific information that HCMC had 242 residents in a 425 bed hospital. The firm then applied the *average* cost data found by the HCFA to be appropriate on a *national* basis (i.e., an increase in costs of 4.7% for each increase of .10 in the hospital's ratio of residents to beds). Record at 216, 511-12 (Touch Ross calculations).

[12] Daniel McLaughlin, the administrator of HCMC, testified that the Minnesota Association of Public Teaching Hospitals, consisting of four teaching hospitals in HCMC's area, considered a study to identify specifically the teaching costs. The cost would have been $500,000 for the whole group. Record 146-47. The administrative record, however, does not indicate the cost for such a study if undertaken solely by HCMC.

ber of occasions that Congress granted the Secretary broad discretion to develop regulations under the Medicare statute. *See, e.g., Humana, Inc. v. Heckler*, 758 F.2d 696, 699 (D.C.Cir. 1985), *cert. denied*, 474 U.S. 1055, 106 S.Ct. 791, 88 L.Ed.2d 769 (1986); *Villa View Community Hospital v. Heckler*, 728 F.2d 539, 543 (D.C.Cir. 1984); *Richey Manor, Inc. v. Schweiker*, 684 F.2d 130, 134 (D.C.Cir. 1982). Accordingly, the Secretary's interpretations of the statute and, especially, the Secretary's interpretations of the agency's own regulations are entitled to great deference. *Humana v. Heckler*, 758 F.2d at 699; *see City of Austin, Texas, Bradkenridge Hospital v. Heckler*, 753 F.2d 1307, 1313 (5th Cir. 1985) (deference to Secretary in context of Medicare legislation is especially strong in case where Secretary is interpreting his own regulations because Secretary has primary responsibility for interpreting the statute); *see also Fairfax Nursing Center, Inc. v. Califano*, 590 F.2d 1297, 1301 (4th Cir. 1979) (provider bears burden of establishing that its costs exceeded the cost limits). HCMC does not contest the validity of the regulation. Rather, the sole issue confronting this Court is whether the Secretary correctly interpreted the agency's own regulation the specificity showing required of the provider. The Court of Appeals for the Eighth Circuit confronted the exact issue when a provider in plaintiff's peer group attempted to use the same HCFA study. *St. Paul-Ramsey Medical Center v. Bowen*, 816 F.2d 417 (8th Cir. 1987). The Eighth Circuit held that "it was not improper to allocate to [the provider] the burden of producing specific data to prove the atypicality of its costs." *Id.* at 419. In light of the Eighth Circuit's interpretation of a provider's exact same attempt to use the HCFA study to prove specificity and in keeping with this Circuit's indications of the high degree of deference accorded the Secretary in interpreting the Medicare statute, the Court shall find that the Secretary did not arbitrarily and capriciously require the provider to furnish specific data regarding

the manner in which HCMC's actual indirect costs associated with its graduate medical education program exceeded the cost limits.

II. THE PROMULGATION OF THE TEACHING ADJUSTMENT FACTOR DOES NOT MANDATE AN ACROSS THE BOARD RETROACTIVE CORRECTIVE ADJUSTMENT.

Plaintiff next argues that the Secretary is required as a matter of law to grant HCMC a retroactive corrective adjustment. Plaintiff argues that the Secretary's inclusion of a "medical education cost adjustment factor" for the cost years beginning in July, 1980 essentially amounts to a recognition that the reimbursement method covering HCMC's 1980 cost year was inadequate. Plaintiff maintains that because the method governing HCMC's 1980 cost year failed to consider the increased costs experienced by providers which operate graduate medical education programs, the Secretary must grant a retroactive cost adjustment as directed by the Medicare statute. 42 U.S.C. § 1395x(v)(1)(A)(ii) (the Secretary shall provide "suitable retroactive corrective adjustments, where . . . the reimbursement produced by the methods of determing costs proves to be either inadequate or excessive").

Only one Court has considered this express issue of whether the teaching adjustment factor governing cost limits after July 1981 requires a retroactive cost adjustment. *See St. Paul-Ramsey Medical Center v. Bowen*, 816 F.2d 417 (8th Cir. 1987). The Eighth Circuit held that section 1395x(v)(1)(A)(ii) "imposes a statutory duty upon the Secretary *whenever* the chosen method of cost calculation fails to adequately reimburse all reasonable costs." *Id.* at 420. The Eighth Circuit remanded the case to the district court directing the district court to "order the Secretary to retroactively apply the 1980 Indirect Teaching Cost Adjustment to the hospital's application for reimbursement." *Id.*

The Eight Circuit's decision and order appear to conflict with this Circuit's decision in *Georgetown University Hospital v. Bowen*, 821 F.2d 750 (D.C.Cir. 1987), *cert. granted*, —— U.S. ——, 108 S.Ct. 1073, 99 L.Ed.2d 232 (1988). While *Georgetown University* did not involve the issue of the retroactivity of the teaching adjustment factor, the court discussed the meaning of section 1395x(v)(1)(A)(ii).[18] The D.C. Circuit stated that the section is not "broad authority for the promulgation of retroactive cost-limit rules." *Id.* at 759. Rather, the section is narrowly drawn to permit

> the Secretary to adjust the reimbursements of particular providers upon proof that his "methods of determining costs" (including his cost-limit rules) resulted in inadequate or excessive reimbursements to those providers. . . . Like any measuring device, the Secretary's regulations will be subject to a certain degree of error, inevitably resulting in "inadequate" or "excessive" reimbursements to *some providers.*

Id. at 759-60. According to this Circuit, Congress enacted section 1395x(v)(1)(A)(ii) to cover those situations in which the Secretary's regulations prove inadequate to recompense fully an individual provider for its reasonable costs. Given the *Georgetown University* court's holding that section 1395x(v)(1)(A)(ii) is narrowly drawn

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[18] *Georgetown University* involved the Secretary's promulgation of a wage-index rule as part of his cost limit regulations. The Secretary issued the rule in 1984 and gave it retroactive effect to all cost accounting periods beginning on or after July 1, 1981. Pursuant to the regulation, the amount the Medicare program would have recouped was in excess of two million dollars. The issue before the D.C. Circuit was whether the Secretary could enact a broad retroactive regulation pursuant to his authority to enact cost limits, 42 U.S.C. § 1395x(v)(1)(A), or pursuant to his authority to provide for retroactive cost adjustments, *id.* at § 1395x(v)(1)(A)(ii).

to provide the statutory authority for the Secretary to grant retroactive corrective adjustments to "particular providers" whose reimbursements prove inadequate because of the "methods of determining costs," this Court declines to follow the Eighth Circuit's decision that the teaching adjustment factor must be retroactively applied.

III. THE SECRETARY, ON REMAND, SHALL GRANT A RETROACTIVE CORRECTIVE ADJUSTMENT IF HCMC DEMONSTRATES THAT IT, INDIVIDUALLY, SUFFERED REASONABLE COSTS ATTRIBUTABLE TO THE OPERATION OF ITS GRADUATE MEDICAL EDUCATION PROGRAM.

This Court, however, finds that under the case law section 1395x(v)(1)(A)(ii) *requires* a retroactive corrective adjustment if a *particular* provider demonstrates that *it* was reimbursed inadequately. *See Georgetown University*, 821 F.2d at 760 (retroactive cost adjustments are appropriate upon an evidentiary demonstration that an individual provider was excessively or inadequately reimbursed); *Tallahassee Memorial Regional Medical Center v. Bowen*, 815 F.2d at 1454 (section 1395x(v)(1)(A) grants the Secretary limited "power to make corrective adjustments in the reimbursement of individual hospitals"); *Regents of the University of California on Behalf of University of California, Davis Medical Center v. Heckler*, 771 F.2d 1182, 1189 (9th Cir. 1985) (section 1395x(v)(1)(A)(ii) imposes "a duty upon the Secretary to ensure that the necessary corrective adjustments are made whenever the methods of cost calculation fail to reimburse a provider for its reasonable costs"); *Cambridge Hospital Association, Inc. v. Bowen*, 655 F. Supp. 439, 448 (D. Minn. 1987) ("it is unjust to shift the cost of Medicare to the provider, particularly where the provider's costs are eminently reasonable. The Secretary has a statutory duty to determine whether the cost limits have produced an inequitable result in a given case"). Given

the case law, the Court determines that the Secretary must grant a retroactive cost adjustment if an individual provider demonstrates that it experienced reasonable expenses in excess of the cost limits for a given year. The Court determines that this does not amount to a broad retroactive rule in contravention of *Georgetown University* because the Secretary must review each provider's case individually.

In this case, the parties agree that health care providers with graduate medical education programs experience higher operating costs. In light of this fact, the Secretary implemented the teaching adjustment factor. While the Secretary is precluded from retroactively applying the regulation across the board, the Secretary's regulation amounts to a recognition that the methods of setting the cost limits for providers with graduate education programs were inadequate and providers may have been compensated inadequately. The Secretary, therefore, must consider whether HCMC, itself, suffered inadequate compensation. In light of what the Court considers to be an acknowledgement that a given method was faulty and because the Secretary failed to adequately consider whether the HCMC had demonstrated that it individually suffered inadequate reimbursement and might be entitled to a retroactive corrective adjustment, the Court shall grant summary judgment for plaintiff as to Count II and remand this case to the Secretary for further proceedings in light of this opinion.

CONCLUSION

For the foregoing reasons, the Court shall grant summary judgment in favor of plaintiff as to Count II of HCMC's complaint and remand the case to the Secretary for further proceedings in accordance with this opinion. The Court shall grant summary judgment in favor of defendant as to Count 1.

ON MOTION FOR RECONSIDERATION AND CLARIFICATION

In a memorandum opinion and accompanying order filed March 17, 1988, this Court granted summary judgment in favor of defendant as to Count I of plaintiffs' complaint. As to Count II of the complaint, the Court granted summary judgment in favor of plaintiffs, Hennepin County and Hennepin County Medical Center (collectively, "HCMC"), and remanded the case to the Secretary of the Department of Health and Human Services (the "Secretary") for further proceedings in accordance with the memorandum opinion. Presently before the Court are defendant's motion for reconsideration and clarification and HCMC's motion for clarification. Defendant argues initially that the Court's ruling on Count II is erroneous as a matter of law. Alternatively, the government maintains that the sole avenue under which HCMC may proceed is 42 C.F.R. § 405.460(f) and requests the Court amend its order to reflect this clearly.[1] HCMC requests that the Court modify its order to reflect that on remand the Secretary bears the burden of establishing that HCMC received adequate reimbursement under the Secretary's cost limits.

The Court has carefully considered the parties' motions. With 42 U.S.C. § 1395x(v)(1)(A)(ii), Congress authorized the Secretary to promulgate regulations which "shall . . . provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." In its March 17, 1988

[1] In 1986, the Medicare regulations were redesignated in the Code of Federal Regulations. The regulation pertinent to this case, 42 C.F.R. § 405.460, now is designated as 42 C.F.R. § 413.30. For convenience and in keeping with the memorandum opinion, however, the Court shall cite to the regulation in its original form as 42 C.F.R. § 405.460.

opinion, the Court found that the teaching adjustment factor amounted to a recognition that the method of setting the cost limits for providers with graduate education programs was inadequate. As such, the Court remanded the case to the Secretary to consider whether HCMC demonstrated that it individually was reimbursed inadequately.

The statute directs the Secretary to promulgate regulations which address the instances when a reimbursement method proves to be inadequate. The Secretary did this. The Court finds that the regulatory framework is the exclusive means for HCMC to proceed at the agency level. Under this scheme, where the particular provider demonstrates that it individually was reimbursed inadequately, then the Secretary must provide a corrective adjustment. *See* Memorandum Opinion, March 17, 1877 [sic] at 14-15. The Court found that the teaching adjustment factor amounted to a recognition that the methods for reimbursement were inadequate. However, given the case law and regulatory scheme, the individual provider must demonstrate that it individually was reimbursed inadequately. Under the regulatory scheme, HCMC must demonstrate that, when compared with other providers in its group, HCMC incurred reasonable increased costs attributable to an approved medical education program, and that these costs are separately identified and verified by the intermediary.

In consideration of the motions and in keeping with the foregoing discussion, it is this 31st day of May, 1988,

ORDERED that the Court's opinion and accompanying order of March 17, 1988 is amended solely to reflect that the exclusive means for HCMC to proceed is pursuant to 42 C.F.R. § 405.460(f); and it is

FURTHER ORDERED that HCMC's motion for clarification is denied and that HCMC bears the burden of proof under the regulatory scheme.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 87-366

HENNEPIN COUNTY AND HENNEPIN COUNTY MEDICAL CENTER,

Plaintiffs,

v.

OTIS R. BOWEN, M.D.,

Defendant.

ORDER

In consideration of the cross-motions for summary judgment, the oppositions thereto, the arguments of counsel, and the entire record of this case, and in accordance with the memorandum opinion accompanying this Order, it is this 16th day of March, 1988,

ORDERED that summary judgment as to Count I of plaintiffs' complaint shall be entered in favor of defendant; and it is

FURTHER ORDERED that summary judgment as to Count II of plaintiffs' complaint shall be entered in favor of plaintiffs; and it is

FURTHER ORDERED that Count II of plaintiffs' complaint is remanded to the Secretary for further proceedings in accordance with the Court's memorandum opinion accompanying this Order.

/s/ Thomas F. Hogan
THOMAS F. HOGAN
United States District Judge

APPENDIX C

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 87-0366

HENNEPIN COUNTY AND HENNEPIN COUNTY MEDICAL CENTER,

Plaintiffs,

v.

OTIS R. BOWEN, M.D.,

Defendant.

[Filed June 1, 1988]

ORDER

In a memorandum opinion and accompanying order filed March 17, 1988, this Court granted summary judgment in favor of defendant as to Count I of plaintiffs' complaint. As to Count II of the complaint, the Court granted summary judgment in favor of plaintiffs, Hennepin County and Hennepin County Medical Center (collectively, "HCMC"), and remanded the case to the Secretary of the Department of Health and Human Services (the "Secretary") for further proceedings in accordance with the memorandum opinion. Presently before the Court are defendant's motion for reconsideration and clarification and HCMC's motion for clarification. Defendant argues initially that the Court's ruling on Count II is erroneous as a matter of law. Alternatively, the government maintains that the sole avenue

under which HCMC may proceed is 42 C.F.R. § 405.460(f) and requests the Court amend its order to reflect this clearly.[1] HCMC requests that the Court modify its order to reflect that on remand the Secretary bears the burden of establishing that HCMC received adequate reimbursement under the Secretary's cost limits.

The Court has carefully considered the parties' motions. With 42 U.S.C. § 1395x(v)(1)(A)(ii), Congress authorized the Secretary to promulgate regulations which "shall . . . provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." In its March 17, 1988 opinion, the Court found that the teaching adjustment factor amounted to a recognition that the method of setting the cost limits for providers with graduate education programs was inadequate. As such, the Court remanded the case to the Secretary to consider whether HCMC demonstrated that it individually was reimbursed inadequately.

The statute directs the Secretary to promulgate regulations which address the instances when a reimbursement method proves to be inadequate. The Secretary did this. The Court finds that the regulatory framework is the exclusive means for HCMC to proceed at the agency level. Under this scheme, where the particular provider demonstrates that it individually was reimbursed inadequately, then the Secretary must provide a corrective adjustment. *See* Memorandum Opinion, March 17, 1877 [sic] at 14-15. The Court found that the teaching adjustment

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[1] In 1986, the Medicare regulations were redesignated in the Code of Federal Regulations. The regulation pertinent to this case, 42 C.F.R. § 405.460, now is designated as 42 C.F.R. § 413.30. For convenience and in keeping with the memorandum opinion, however, the Court shall cite to the regulation in its original form as 42 C.F.R. § 405.460.

factor amounted to a recognition that the methods for reimbursement were inadequate. However, given the case law and regulatory scheme, the individual provider must demonstrate that it individually was reimbursed inadequately. Under the regulatory scheme, HCMC must demonstrate that, when compared with other providers in its group, HCMC incurred reasonable increased costs attributable to an approved medical education program, and that these costs are separately identified and verified by the intermediary.

In consideration of the motions and in keeping with the foregoing discussion, it is this 31st day of May, 1988,

ORDERED that the Court's opinion and accompanying order of March 17, 1988 is amended solely to reflect that the exclusive means for HCMC to proceed is pursuant to 42 C.F.R. § 405.460(f); and it is

FURTHER ORDERED that HCMC's motion for clarification is denied and that HCMC bears the burden of proof under the regulatory scheme.

/s/ Thomas F. Hogan
THOMAS F. HOGAN
United States District Judge

APPENDIX D

42 U.S.C. Section 1395x(v)(1)(A)

(v) Reasonable costs

(1) (A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method

reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.